COUNTWAY LIBRARY
HC 2HHU 9

INTERNATIONAL CLINICS

Supplement March, 1934

Clinical Case Studies 1-2

HARVARD UNIVERSITY
SCHOOL OF MEDICINE AND PUBLIC HEALTH
LIBRARY
1 MAY 1936
Replacement

FROM THE RECORDS OF THE
PITTSBURGH DIAGNOSTIC CLINIC
3509 FIFTH AVE. PITTSBURGH

PRINTED IN THE UNITED STATES OF AMERICA

FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly, but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Male Single Age 25 years

CHIEF COMPLAINT

Attacks of pain in the precordial region and the right upper flank.

PRESENT ILLNESS

The complaint which brings this patient to the Clinic is pain, at first limited to the precordial area, but recently most intense in the right upper flank, coming in two severe attacks, between which he has noticed a slight, but fairly persistent discomfort in the same regions. The first attack developed about a month ago, lasted fourteen hours, and was so severe that he was unable to get up off the bed. The pain was limited to the precordial area, radiating from the front up to the right shoulder and into the right interscapular region behind; he states that it was constant and very severe. Following this he suffered with a chronic nagging discomfort in the same region; then, about two weeks ago it began to involve the right upper flank. Nine days ago he developed the second attack of severe shooting pain in the right upper flank, radiating through from the front to the back, but not down the flank or into the testicle or penis. This second attack lasted about the same length of time; neither attack was accompanied by any nausea or vomiting; in fact, the gastro-intestinal tract apparently had no relation to the attacks of pain. No chills or sweats.

The patient states that about two years ago he developed a venereal infection, characterized by urethral discharge; treated by a physician for eight months, who finally had a blood test

made which was reported as indicating syphilis. The patient thereupon changed to his present physician about one year ago and underwent treatment; he was given injections intravenously, being in the hospital apparently for this purpose for about a week. He then went home and in about ten days developed urinary disturbances, characterized by bleeding, pain, and passage of "tissue" from the penis. He was put back in the hospital for about two weeks because of this condition and the urinary symptoms promptly subsided. Three blood tests have been made since that time, the first one showing mildly positive, the second negative, and the third negative. His health then remained fairly good until the onset of the present symptoms one month ago; weight has been about stationary. Appetite and digestion good. In general, he feels weak, nervous, and apprehensive.

PAST HISTORY

Past history entirely negative up until the onset of the present illness. He was born in Italy, came to this country nine years ago; no history of any illness while in Italy except for a mild attack of influenza in 1918. No trouble with the eyes, ears, nose, throat, heart, lungs, gastro-intestinal, or genito-urinary tracts.

Habits—regular as to hours of eating and sleeping; alcohol very rarely; tobacco—about fifteen to twenty cigarettes daily. Works hard in a mill near a hot furnace.

Social history—patient is unmarried.

Venereal history—given in detail under present illness.

Family history—negative.

PHYSICAL EXAMINATION

GENERAL

Height 69 inches Weight 146 pounds Temperature 98°

Patient is well developed, quite muscular, rather poorly nourished. He appears introspective and apprehensive. There is no cyanosis, jaundice, or eruption.

HEAD AND NECK

Ears—negative. Eyes—pupils moderately dilated, equal, react about normally to light and accommodation. Moderate diffuse injection of the sclerae. Mouth—teeth well preserved, gums are clean. Throat—moderately injected, tonsils are small, no signs of infection. Glands—no general enlargement; thyroid —not enlarged.

THORAX

Lungs are clear throughout.

Heart—normal size, rate is 72, regular in force and rhythm; sounds are all clear, no murmurs. Pulse—72, regular, no abnormal thickening of vessel wall.

ABDOMEN

No masses or areas of tenderness; spleen not felt; liver to costal margin, edge not felt; deep palpation over the right kidney does not disclose any tenderness or enlargement.

EXTREMITIES

No edema; reflexes are all normal; no tremor.

BLOOD PRESSURE

Systolic 135.
Diastolic 65.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.

GENERAL HISTORY

White Male Married Age 37 years

CHIEF COMPLAINT

Swelling of the right side of the neck, together with choking sensations.

Recurring periods of cough, occasional spitting of blood, night sweats, and pains in the right chest.

PRESENT ILLNESS

The patient has been sick since last March,* at which time he developed severe pain through the right chest, coming on suddenly, and followed in about 24 hours by fever, cough, and signs that led to a diagnosis of broncho-pneumonia and pleurisy. These acute symptoms subsided in about ten days, but since then he has not been well, by reason of recurring signs and symptoms, as follows: There have been recurrences of a severe cough with spitting up of mucoid material and on three occasions the sputum was streaked with bright red blood for several days at a time. There has also been considerable shortness of breath at times and severe sweats, limited to the upper portion of the body, from the waist up, including the head. These symptoms would be quite severe for a week or two, then subside and he would be comparatively free from them for a variable period of from a few days to a week and then they would recur and this has continued to the present time. He has been in bed most of the time since the acute onset last March. About a month or six weeks ago he noticed a small swelling above the right collar bone and a little later similar swellings along the right side of the neck. These are not particularly sore, do not interfere with turning of the head, but seem to bulge out when

* Date of examination—October.

he coughs and when he rubs them the skin becomes red. They have increased in size somewhat since the original appearance, but there has not been any diminution in size. About three weeks ago he was feeling better in most respects but caught another slight cold and about ten days ago he developed soreness around the right costal margin and over the ribs on the right side, this latter soreness apparently being subcutaneous and not deep. At this time he also developed sensations of marked fullness and heaviness in the stomach when he would eat even a small amount of food. These latter symptoms have improved considerably in the past week.

Briefly, then, he had an acute onset last March, suggestive of a pulmonary condition such as a pneumonia and pleurisy, and since that time has had recurring bouts of fever, sweats, severe cough, and occasional spitting of blood. More recently, apparently in the past month to six weeks, he has developed large glands in the right side of the neck, not painful or interfering with turning of the head and still more recently, about ten days or two weeks ago, he developed soreness about the liver region. Throughout all this there has been practically no change in his weight; he has not felt particularly weak. During the earlier stages of the pulmonary symptoms he was quite short of breath on any exertion but states that during the past two or three weeks this dyspnea has almost entirely disappeared. Except for the period about ten days ago when he had the fullness in the stomach after eating, his appetite has otherwise been normal and his bowels regular. He has not had any nausea or vomiting.

PAST HISTORY

The only significant feature in the past history is severe recurring tonsillitis with occasional attacks of quinsy, beginning when the patient was 20 years of age and continuing for about 7 years, at which time he had another severe quinsy and since that time no sore throat. Otherwise, past history is entirely negative. No history of any acute or chronic infectious disease; always strong, well, and active.

Habits—apparently somewhat irregular as to hours of eating and sleeping; smoked a pipe almost constantly. Until the past two or three weeks since the age of 20 he drank from two to six moderate drinks of whiskey every day and also would drink beer and wine. In the past two or three weeks he has given up the whiskey but continues to drink wine with his meals.

Venereal history—negative.

Family history—married 13 years, two children ages 12 and 11, living and well; wife had one miscarriage six years ago at five months; wife is living and well. Father and mother died at their home in Italy of unknown cause.

PHYSICAL EXAMINATION

GENERAL

Height 66 inches Weight 172 pounds Temperature 99°

Patient is the short, stocky, powerful build, excellent musculature, does not appear at all nervous or introspective, and does not seem at all cachectic or weak; there is no evident dyspnea during the taking of the history. No cyanosis or jaundice.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, associated movements are normal. Mouth—teeth are well preserved, gums show moderate pyorrhea, no lead line. Throat—moderately injected, tonsils are fair size, rather deep, do not appear infected; there is no bulging to be seen in the throat on either side, or any disturbance of throat muscles. Tongue protrudes in the midline, coated, otherwise normal. Neck—there is considerable bulging of the right side of the neck and a series of enlarged glands beginning with one just over the right clavicle about the size of a walnut and continuing in a chain, apparently under the sternocleidomastoid, the highest one being just at the tip of the mastoid. These glands seem discrete, freely movable, not tender, and are rather soft, but there is no fluctuation. There is no redness or heat of the skin over the enlarged glands; no limitation of motion of the neck; no dullness under the right clavicle. On the left side of the neck the postcervical glands are palpable, seem deep, discrete, and of the same consistency as the larger glands on the right side. Axillary glands palpable; epitrochlears shot-like; inguinal glands only barely palpable, not more than one usually finds.

THORAX

Percussion note is somewhat impaired over the entire right lung, particularly from the interscapular region down, and breath sounds are almost absent over the entire lung, especially over the lower lobe behind. Occasionally, during expiration a few faint, dry, sibilant rales are audible, a little suggestive of a possible asthmatic type of breathing. Tactile fremitus is diminished over the entire right chest below the interscapular region. These findings are suggestive of a thickened pleura, although there may be some condition interfering with inspiration into the right lung. Left lung is negative throughout.

Heart—normal size, does not seem to be pushed to the left. Point of maximal impulse in fifth interspace, just in midline; rate is 100, regular in force and rhythm. Sounds are rather impure, but no definite murmur can be heard. At the left sternal border the aortic second is accentuated, but no diastolic murmur is heard. Over the aortic area the heart sounds are not heard, although there is no abnormal dullness in this location. Pulse—100, regular, no abnormal thickening of vessel wall.

ABDOMEN

There is enlargement of the liver about 5 cm. below the costal margin, extending across in the midline and merging under the left costal margin. Liver edge seems normal contour, liver is fairly firm, no nodules can be made out. There is slight tenderness on palpation of the liver. Liver dullness to fourth interspace above; no tenderness or abnormality over lower abdomen; spleen is not palpable.

EXTREMITIES

No edema; reflexes are all normal except that the knee jerks are somewhat less active than one usually finds. No tremor of the fingers.

BLOOD PRESSURE

Systolic, 130.
Diastolic, 85.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration reports requested on special studies.